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Leadership: Understanding Community Nursing in Scotland

End of Grant Report

The University of Edinburgh

School of Health in Social Science

Nursing Studies

Leadership: Understanding Community Nursing in Scotland

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Introduction

Leadership in nursing has grown in significance over past decades (Jasper 2002). Nurses and midwives, as the largest group of health care professionals within the National Health Service (NHS), are targeted by policy makers as key contributors not only for care delivery but also to achieve politically desired changes (for example: SEHD 2005, 2006a, SG 2007). Leadership is one of the key factors identified in policy documents as being required to achieve a better quality and fairer health care system (DoH 2006, 2008, 2009, 2009b). Emphasising leadership in health care in such a way has implications for nursing and nursing leadership since both are directly affected by health care policies and politics (Antrobus & Kitson 1999, Maslin-Prothero *et al.* 2008).

The focus of the following study was to identify how leadership is perceived and experienced by community nurses across Bandings and how policy interacted with the development of leadership in community nursing in Scotland. The Local Research Ethics Committees and the Research and Development departments granted their approval in all three health board areas prior to commencing the study.

Aims and study questions

The aim of the study was two-fold: (1) to identify how leadership is perceived and experienced by community nurses and (2) to examine the interaction between recent policy and leadership development in community nursing.

The team sought answers to the following specific research questions:

1. What is the nature of leadership for nurses (Band 6 and 7 SPQ practitioners and their junior colleagues) working in the community?
2. Has leadership changed for nurses in relation to recent policy developments, if so how and why?
3. How is leadership experienced and perceived by community nurses?

4. What is the impact of current leadership processes on work force planning and workload management?
5. How are professional development and quality care of care assured in nursing teams?
6. What positive and negative outcomes do community nurses ascribe to current leadership processes?
7. How can community nurses be supported to develop effective leadership in a new policy context?

Study design and methods

The study design was qualitative in nature using individual interviews (N=31) and focus groups (N=3) as methods. Data were gathered from district nurses (DN), health visitors (HV), community staff nurses (CSN), nursery nurses (NN), health care assistants (HCA), team leaders (TL), lead nurses (LN), an assistant nursing director (AND) and nursing directors (ND) between April and December 2009.

Data Collection

The initial interview and focus group schedule were developed after reviewing the literature on leadership in nursing and community nursing and research questions posed by QNIS. Subsequent schedules evolved from preliminary data analysis allowing the team to explore emerging themes in more depth. Following consent, all interviews and focus groups were digitally recorded and transcribed verbatim.

Recruitment

Recruitment was from urban, mixed (urban – rural) and remote areas in three health boards in Scotland. Access to participants was sought through Directors of Nursing and the study information was cascaded to participants. Recruitment and therefore data collection was seriously affected in one area by the outbreak of H1N1 influenza during the late spring and early summer months in 2009 as community nurses were drawn into the front line response to the outbreak.

Demographic data

The overall sample indicates a highly experienced workforce (Table 1), reiterating findings from the Review of Community Nursing study (SG 2009).

Table 1: Work experiences of community nurses

	Mean	Range	Number of respondents with over 10 years experience
Years in current community position ¹ (n= 37 respondents)	8.8 years	1 year– 26 years	14 respondents
Years qualified as a nurse ² (n= 35 respondents)	25.85years	5years– 38years	32 respondents
Years of experience in community nursing ³ (n= 33 respondents)	15.37 years	2.5years- 30years	26 respondents

Efforts were made to recruit participants across community nursing qualifications (Table 2). The sample is skewed towards community/ district nurses and community staff nurses since this is the biggest workforce group within community nursing.

Table 2: Overall qualification distribution across sample⁴

District/ Community Nurse	14
Community Staff Nurse	12
Health Visitor	5

¹ Two Nursing Directors are excluded from this sample.

² Two Health Care Assistants and 2 Nursery Nurses are excluded from this sample.

³ Two Health Care Assistants, 2 Nursery Nurses and 2 Nursing Directors are excluded from this sample.

⁴ Note: Team leaders have been assigned according to their qualification either as DN or HV. One lead nurse and both nursing directors have acute care backgrounds.

School Nurse	0
Nursery Nurse	2
Health Care Assistant	2
Acute Care Managers for Community Sector	1
Assistant Nursing Director	1
Director of Nursing	2

Efforts were made to recruit participants across Banding (Table 3). Area 2 was the only area which did not have any Band 6 community nurses.

Table 3: Band distribution of participants according to areas

	Area 1	Area 2	Area 3
Band 2	2	0	0
Band 4	2	0	0
Band 5	5	4	3
Band 6	6	0	3
Band 7	5	2	1
Band 8	2	1	1
Executive level	1	1	0

In the following section key findings are presented in respect of each research question.

Findings

I think that maybe we've sort of lost a sense of who we are and what we're doing somehow.There's not a culture of leading and managing in community nursing.
Team Leader

What is the nature of leadership for nurses (Band 6 and 7 SPQ practitioners and their junior colleagues) working in the community?

The structural organisation of leadership within and across health boards varied and was influenced by national and local political agendas. In one study area, for example, some CN teams were led by social workers while other areas had retained a nursing lead. The CNs enjoyed autonomy in their work and consequently some were reluctant to be lead. Many CNs spoke of working within teams of district nurses or health visitors with little interaction or day to day leadership beyond these immediate teams. Leadership was perceived as hierarchical and 'top down' beyond the immediate team.

Changes in nursing services, of which the joint working initiative was just one amongst others, were evident in all three study areas and based on different policies. Some health visitors had the perception that:

Well, as I said, our perception is that we're just going to be a social work puppet but that's our perception and, you know. They're not happy, the workforce isn't happy. That's why a lot of health visitors have left or taken early retirement..... That's surely – you know, and it's all under child protection but I'm not doing any health promotion, I'm not doing any health work (HV 3.1).

While there is merit in 'joint working' as such, having a social work leader seriously questions the value of professional leadership in nursing. It is unclear how, for example, quality of care can be maintained or even increased, as is frequently demanded in policy papers (Scottish Executive 2006, SG 2007, DoH 2009), if social work leaders do not have an insight into what community *nursing* services can and should provide. Consequently, it is suggested that this sort of detached leadership contributes to the invisibility of community nursing. This interpretation is substantiated by the fact that a number of community nurses who were lead by social workers did not know if there still was a Director of Nursing within their health board area.

Has leadership changed for nurses in relation to recent policy developments, if so how and why?

There was clear evidence across the sample that new leadership positions had been and are being developed to deliver policy agendas. New roles such as *team leaders* and *lead nurses* have evolved, but as the CNs and team leaders explain these are essentially management posts the leading is currently only in the title as these new roles have had little preparation or development for the challenges they present!

I: You were talking earlier about the 50/50 and it's team leader but what you were describing is really management, so where does leadership come in there?

TL1.3: I think in the title (LAUGHS), isn't it? In the leader bit but – well, it depends what you classify as a leader. I would describe it more as staff management and there as a support mechanism for staff.

The lack of preparation of the nurses for new leadership roles was evident in all three areas as was the lack of coaching for the nurses taking on these new and challenging posts.

For those in senior leadership positions policy had a direct impact on their leadership. In fact, it focused leadership around policy delivery. This is evident when a Director of Nursing pointed out that:

[] and even if you think of me in my post, I have a whole range of other things to deliver as well as nursing. If you look at how many points I get for nursing in my end of year review, not that many. Not that many. I have to deliver on a whole range of other things (ND 1.1).

There is a complexity to policy which is often overlooked. It became evident in interviews that 'policies' came from different directions, which included: (1) national policies, (2) health board policies and (3) council policies, all of which have an influence on the delivery of community nursing services. There is, indeed, not a shortage of policies as the following excerpt demonstrates.

[] I think there is a lot of policy. I think it – there's – you know, I think it's – and the policy is national that needs to be translated and then there's the local policy and then there's the council policy. So there's lots of different policy directors (LAUGHS) coming in there and I think part of it really is kind of synthesising that really in some ways in taking it forward (LN 1.2).

These policies need to be 'synthesised' before they result in any service delivery. Hence, the translation of policies into concrete care delivery plans was understood as one aspect of

leadership by those in leadership/ management positions but also by nurses delivering direct patient care.

The extent, to which different policies from various policy making levels interrelated, complimented, contradicted or even counteracted each other remained unclear. The Review of Nursing in the Community (RoNIC) (SG 2009) was one frequently mentioned policy across the sample but discussions reflected the position of the speaker. Nurse leaders from Band 8 upwards, for example, discussed the ongoing review in relation to leadership, focusing on the future direction of community nursing. Nurses on Band 5, 6 and 7 were more concerned about the impact the RoNIC might have on their way of working and discussions remained on a more concrete level of care delivery.

The impact of numerous projects was felt by nurses and is evident in the following contribution:

There's a lot of change going on at the moment and I think it's a bit – makes you feel a bit restless. Certainly (LAUGHS). A lot of the girls are very much – well, is there any point in trying to move forward at the moment when we don't know where forward is? (DN 3.4).

'Not knowing where forward is' sums up the uncertainty many CNs experienced emphasizing the lack of leadership and direction setting in the development of community nursing. Good leaders are said to 'have a vision' (Barker 2006, Bass & Riggo 2006, Kouzes & Posner 2007) and whether there was 'a vision' in these particular health board areas remained unclear. Data suggest that this 'vision' was not communicated to staff in such a way that staff knew either about the 'vision' or 'where forward was'. Hence, the future of community nursing remained elusive to these nurses. Further, there is evidence that the prolonged RoNIC review process resulted in delaying the up-take of community nursing qualification, which has to be of concern to current and future leaders in community nursing and policy makers. Given that this is an experienced and, therefore, a mature workforce, it is reasonable to expect that the impact of a reduced number of qualified community nurses will be felt within the next decade or so.

Indeed during the six months data collection, the Nurse Directors when re-interviewed, explained the rapid and significant changes in leadership they were making to the organizational structure

and layers of leadership to ensure *shifting the balance of care* could be achieved. Policies focus leadership in community nursing on the delivery of different policies rather than the development of the profession.

How is leadership experienced and perceived by community nurses?

Many participants mentioned characteristics of leaders, some participants also mentioned that a good leader should ‘have a vision’ of where the service is going. The listing of ‘qualities’ conforms to a trait perspective on leadership with an exclusive focus on the leader and his or her qualities or attributes, linking these qualities to effective leadership (Bratton *et al.* 2005, Northouse 2007). Leadership was very much experienced within the hierarchical structure of the NHS and either appeared to be running alongside the managerial hierarchy or was synonymous with management. While ‘being visible’ was one of the leader qualities often mentioned by participants, the organisation of leadership within a hierarchical NHS structure had implications for the visibility of their leaders. Data suggest that the leaders who did not have a ‘visibility’ problem were at the team leader level. Where there were team leaders nurses felt that:

[] I would say (name of team leader) definitely more – what’s the word? – she’s – she’s there and we know she’s there and she’s around all the time. [] And she – you know, she is in and out – interact quite a lot, so – you know, although it’s no specifically maybe been for me to go and do things, you know, it’s probably been more for Band 6s. But she’s definitely more around (DN 1.4).

This view is substantiated by other nurses across the sample but also by team leaders, who understood the importance of their visibility and made efforts to be visible. It appears from the data that distance did have an impact on whether nurses saw any of their leaders above the team leader level, in remote locations physical distance is a barrier to leadership. Nurses in urban areas did not necessarily have the same experience. It was however not always the physical distance that inhibited the visibility of leaders. Many participants on lower Bands pointed out that they ‘never saw’ any of their lead nurse, assistant nurse directors or directors of nursing. This situation was exacerbated in some areas by a recent change which saw the exclusion of Band 5 nurses and below from DN meetings in which, for example, lead nurses would

participate and discuss changes. These meetings had become exclusively Band 6 and above meetings, which, in effect underlines the hierarchical nature of leadership within the NHS.

In summary, while participants agreed on the characteristics of a good leader, leadership as such was experienced within the hierarchy of the NHS. Contact, visibility, and thus communication, of and between lead nurses or Director of Nursing was most commonly restricted to nurses from Band 6 and upwards through attending meetings. Direct contact to Directors of Nursing was not reported by any participant below Band 8, unless there was a problem. This organisation of leadership is in sharp contrast to the leadership literature which frequently argues the transcendence of effective leadership on all levels (Edmonstone 2005, Stanley 2005, Goodwin 2006, Stanley 2006, 2008).

What is the impact of current leadership processes on work force planning and work load management?

Community nurses across banding described themselves as ‘being autonomous’ and having a higher degree of ‘independence’ compared to their colleagues in hospital. In fact, a number of CNs argued that it was the lack of hierarchy in community nursing that attracted them to community nursing. This preference for independence in the community workforce is pointed out by the following lead nurse.

I always kinda feel that – that in the community we’re all the independent kind of folk who, you know, escape from the institution of the hospitals, so everybody tends to be people who kind of like to go and do their own thing and have a wee bit of autonomy, great, you know, and that’s great cos you have really strong folk (LN1.2).

However, it is also in this context that one team leader argued that ‘*there’s not a culture of leading and managing in community nursing*’ implicitly questioning the effectiveness of leadership in community nursing. There is indeed the question how a service that has ‘no culture of leadership or management’ can be lead? It could be argued that it is exactly the lack of leadership in community nursing that exposed the workforce to the demands of others, for example, policy makers or general managers in the NHS and currently social services.

From a management perspective, however, a more flexible workforce is needed in order to satisfy ever changing care demands.

I know many areas have kinda gone geographical, etc. And that's really hard for people who had built up a very close kinda leadership team thing going in their own little practice area but, quite frankly, it kinda can't work at the moment because the level of work that's coming in necessitates the nursing teams to work more closely together cos they're so small – there's 2 or 3 people and 2 or 3 people and, you know, whereas you pull 6 together and you might have the start of something a bit more manageable in terms of the workload. (LN 1.2).

While leaders acknowledged that CNs did not like some changes such as 'going geographical' a clear advantage of having the workforce working differently is for managers to have power to control *where* and *what* their work force did-particularly in relation to *shifting the balance of care* policy. The expectation is to move staff around in community to meet health care need and move staff between acute and primary care settings.

The new roles being developed to lead teams has lead to 'backfill' direct patient care now being delivered by lower band nurses. Data suggest that there is a drive towards increasing Band 5 nurses in the community and decrease Band 6 & 7 nurses. The following excerpt reflects the situation in two health board areas.

I mean, one of them (Band 7) is coming up to retirement at the end of this month and will be replaced by with staff nurses, not with a – somebody with a community nurse qualification and the two staff nurses will be overseen by a community nurse in – district nurse in the other health centre and I think that's the future and they know that – that () band, the old Band 6s, which are now Band 7s retire, they will not be replaced with people with a district nursing certificate. They will be replaced with community staff nurses and there may be one or two qualified district nurses overseeing the whole area (TL 1.2).

It is not clear how quality of care can be maintained or improved when at the same time specialists' community knowledge is decreasing. Some nurses argued that good leadership is influenced by the leader's role-specific knowledge. This view was particularly strong amongst HVs and is evident in the following contribution.

I think it must do because she (her TL) doesn't have any background in health visiting at all. So I suppose – I mean, I think she tries very hard to up-skill on some of the aspects of health visiting and I know she does. I know she's really going along to training courses to up-skill a bit on it but I think by the nature of – she's got decades of district nursing

experience and none in health visiting, so she doesn't actually have that kinda background knowledge about the clinical work that we do HV 1.1).

The role of the HV has changed to such an extent toward child protection that not having this role specific knowledge had implications on how HV were supported or DNs were able to lead HV. In those cases, where the TL was not an HV, it became apparent in interviews that these HVs would seek support from social work or specific child protection officers rather than their team leaders. It is these shifts towards child protection and intensive families in health visiting which further questions the independent working of nursery nurses in CN teams evident in the data, but also how non-HV team leaders are supported in being able to identify support needs, manage workload and plan their HV workforce if they do not fully understand the complexity of HVs daily work.

How are professional development and quality of care assured in nursing teams?

In all three areas of the study participants underwent appraisals and had an individual Personal Development Plan (PDP). Many participants argued that it was not a problem to get further training. Information about training courses was cascaded down from team leaders using the e-mail system as is evident by the following contribution:

Team leaders, yeah. Well, I mean, they just – they just disseminate all the various courses that are available. I mean, they all get emailed through and it's really up to you whether you're interested and want to – to go on them [] If it's something that's going to enhance your work, then you're usually allowed to – allowed to go on it. Sometimes it's getting the time off through, you know, holidays and sickness and things. It's sometimes the only thing that kinda stops you from going on these things. But on the whole, it's not usually a problem (DN 1.1).

Data suggest that nurses felt well informed about further training opportunities in their health board area but courses appeared to be predominately in-house. Courses, which needed funding, needed to be approved by lead nurses since they had control of the education budget. This aspect was not developed to team leaders.

However, if the participant was a NN or HCA the availability and the ease of accessing courses seemed to change. Asked if they could participate in further professional development one HCA pointed out that is was:

Sad. A bit sad really that, you know, if you want to do a bit more in – in that particular role, there is no scope for it. That there's nothing – there's nothing beyond that, which is difficult. [] But I think they would get much, much more and they would get a better service if they had – if the training was in place for – for girls like myself, you know (HCA 1.1).

Therefore, it appears that the ease and availability of further professional development was in place predominately via in-house courses for qualified nurses across all Bandings. However, other health care workers in the community, noticeably NNs and HCAs, appeared to be losing out since it was felt that there was nothing in place to either gain a higher vocational qualification or that preference was given to nurses in allocating course places.

Further, the link between staff training and quality of care was not explicitly argued by either nurses or any leaders. It is possible that this link is implicitly evident and would have been more obvious if the content and themes of the in-house training programme had been reviewed.

What positive and negative outcomes do community nurses ascribe to current leadership processes?

Leadership was viewed as positive when leaders listened, consulted before implementing changes, respected and valued the contributions staff were making to community nursing, explained why things were changing, had an understanding of different policy agendas and motivated staff to develop the service with them. The following contribution was typical across the sample.

What makes a good leader? Someone who has – is aware of obviously the national changes that are going on within community nursing. Someone who has got a vision for that and actually sees a way of taking that forward. Someone who consults with their staff and has consultation but also listens and takes on – listens and takes on board our concerns. And also someone who – I think someone who actually sees it from our perspective as well, you know. Someone who sees what it's like for people working in the community. That would be what I would say. Someone with vision and strong leadership qualities, you know (HV 1.1).

In short, participants across the sample implied in their answers that good leadership is a process, resulting from the interplay between leaders and followers. Some nurses were clear that they would not simply '*follow a numpty*' (DN 2.4) but rather viewed leaders as '*somebody that I would look up to and want to follow*' (DN 3.2). It was very much the choice of the nurse, the follower, to follow a particular leader. This perception correspond with Binney's and colleagues (2009) view, arguing that leadership is not about knowing the answer but very much about the leader's ability to tap into the collective intelligence and insight of groups and organisations in order to collaborate and find solutions to challenges. This suggests that the relationship between leaders and followers is a key aspect of leadership. Put differently, 'thinking leadership without thinking followership is not merely misleading, it is mistaken' (Kellerman 2008:23).

Consequently, and perhaps not surprisingly, negative outcomes of leadership were described as not being listened to, consultations as tokenisms, not being valued, being kept in the dark about changes and why changes were happening and so on. When asked if nurses were consulted about changes the following contributions emerged:

In – of a sort, you know. I always feel we're consulted but you feel as if the end decision's already made before – you know, it doesn't matter how much you say and what – there's been a lotta changes lately and a lotta things that have been quite major changes and so there's been a lotta consultation in that, you know, it's – it feels a bit tokenism (DN 1.4).

It appears from the data that 'consultations as tokenism' happened in relation to major service changes, for example, geographical versus practice based working as well as issues of uniforms.

Participants reported service development ideas which were clearly blocked at management levels before the idea ever reached, for example, the Director of Nursing. It appears that nursing still has a culture that tends 'to eat their young and doesn't celebrate success at all' (McKenna *et al.* 2004:74). This is somewhat in contrast to NHS initiatives which seek recognition of 'outstanding leaders' (letter from David Nicholson, 6.March 2009). Data support the view that there is a lack of leadership from within community nursing which, in turn, functions as a barrier to the development of the profession and should be of great concern to the profession. This insight is supported by others studies which point towards a still existing leadership crisis and a

lack of suitable nursing leaders (McKenna *et al.* 2004, McMurray & Cheater 2004, Poulton 2009).

How can community nurses be supported to develop effective leadership in a new policy context?

Rafferty (1993) undertook a review of leadership in nursing in response to a ‘so-called leadership crisis in nursing’. Rafferty’s review is of interest here because it was set in the context of past changes in the NHS, such as the introduction of general management in 1983. The introduction of a general management structure in the NHS shifted the control from medical professionals towards financial managers with a much greater emphasis on financial efficiency of the service (Bolton 2003). Rafferty (1993:24 & 25) concludes her review by arguing that ‘more attention needs to be paid to clinical leadership and the role of research in leadership development’ in order to develop nurse leaders ‘with vision, a sense of foresight and discernment in diagnosing the way forward’ within the acute as well as the primary care sector.

Data in this study suggest that the state of clinical leadership in nursing is encouraging. Over the past 17 years, a number of specialist nursing roles have emerged and it was these nurses, community nurses referred to when talking about ‘clinical leadership’ as the following excerpt testifies.

[] the nurse specialists who’re maybe not your manager but maybe have skills and have – you would look up to them for a certain area of practice and you would see them as a leader, appreciate them – they might not always – if you were a Band 6, they might not be more senior to you but you might still see them as a leader (DN 3.2).

As the numbers of nurse consultants are still limited and not yet developed in community nursing in Scotland, not all nurses had access to nurse consultants, those who did praised them for their clinical knowledge and their clinical leadership.

The nurse consultants. I think they can often be a really good source. Leadership inasmuch as – yeah, they can – they offer you so much information, they’re always available to speak to, should you have any problems and the fact that they are nurses as well I think can be very good inasmuch as they know where you’re coming from, they know what your responsibilities are and they know exactly the information to give you. (DN 3.4).

In general, the idea of a nurse consultant was seen as positive move for nursing. The role could, as one lead pointed out, help *‘to be more explicit about the professional issues within community nursing and have mechanisms and some leadership around the standard setting (LN 1.2).*

Whether participants spoke about nurse consultants or nurse specialist, these roles often reflected a biomedical orientation in nursing which is evident in their titles: diabetes nurse specialist, palliative care consultant or respiratory nurse specialist and so on. Accordingly, the leadership provided by these nurses focused and remained on the clinical level.

Consequently, and considering other dimensions of leadership, leadership and leadership education in nursing is conspicuously absent. McKenna (2009) points out that the lack of political astuteness in nursing is not surprising given that this aspect of education is still missing in nursing curricula. He goes on in arguing that the sectional interests in nursing ensures that nurses so far have failed to speak with one voice and become a political power to be reckoned with (McKenna 2009). When asked if participants had access to leadership courses the following contributions emerged giving a flavor across the sample:

All the Band 6s had to do a leadership course. It started – it probably started about 8 years ago – 8 years ago before I came into position here and it was a 5 day course. It was run throughout (name of health board) and I think that was through – that was through national guidelines as well that we had to do leadership courses, so it was one that a couple of staff members in (name of town) implemented and we all attended. It was (location) I think we attended for it and it was a 5 day course. Very, very useful, so I probably attended it about 6 years ago. It was interesting. I can’t remember much about it now but I know it was beneficial at the time (DN 3.1).

Or...

What did I do? God, it’s such a long time ago now. I can’t remember – a couple of days on a leadership course (HV 1.1)

There is clear evidence across the sample that nurses had access to leadership courses. However, these courses appeared to be predominately in-house since only two nurses out of the whole sample mentioned to have attended the RCN Clinical Leadership course. Participants talked about ‘a couple of days on a leadership course’ or ‘we had a 5 day course’ which suggest a focus on short term courses. It is however questionable if leaders can truly be educated in short term

courses, which do not necessarily appear to focus on leadership issues and are often one-off events. Importantly only some senior leaders had in place coaches to support them through the challenges of leading. It was evident that people new to leadership roles and people in less senior roles also need this support structure.

It is further the case that the importance of the context of leadership is brought to the fore in the separation of clinical and managerial leadership. Clinical leadership is defined as 'leadership by clinicians of clinicians' (Edmonstone 2005) and these leaders are either appointed (by management) or formally or informally elected (by peers) . Clinical leadership takes a micro perspective in that the focus remains on the patient, client group or a specific service. Clinical leaders are leaders because they are respected by their peers and other health care professionals and have specific clinical knowledge.

Managerial leadership, in contrast, is delivered by appointed leaders who are in a position of power and who operate within specified policies in order to achieve politically set targets (Edmonstone 2005). Managerial leadership takes a macro perspective by focusing on the needs of an organisation. This is what Bolton (2003) refers to when arguing that the introduction of a general management structure in the NHS shifted control from medical professionals towards financial managers with a much greater emphasis on financial efficiency of the service. This difference in NHS leadership is of importance since it pinpoints the different roots of 'leadership' in health care. In stating the obvious, clinical leadership resides with health care professionals and is linked to the development of professional practice, while managerial leadership is a result of the introduction of a general management structure.

Conclusion

In sum, leadership was very much experienced by nurses across Banding through the hierarchical managerial structure of the NHS with little input from front line nurses themselves. National and local political agendas set the direction of any leadership initiative within health boards and data suggest that a top-down approach was common.

It is crucial to understand and acknowledge the difference between clinical leadership and managerial leadership. It is evident from the data in this study, which also links to the current nursing leadership literature that the focus within nursing remains on clinical aspects of leadership. There is no doubt that a profession needs clinical leaders but, and perhaps ironically, they need managerial nursing leaders too. Antrobus and Kitson's (1999) framework shows that leadership goes beyond clinical leadership to encompass political, clinical executive and academic aspects.

In order to enable future leaders in nursing, who will need to focus beyond the clinical environment and need to develop a number of competencies which include the ability to develop a global perspective or mindset about healthcare and professional issues; the ability to integrate new technology which facilitates mobility and portability of relationships, interactions and operational processes; develop expert decision making; creating an organisational culture that recognises quality healthcare; understand and intervene in political processes; have the ability to balance authenticity with performance expectations and finally, are visionaries and proactive in response to rapid changes in everyday healthcare (Huston 2008) a national nursing leadership programme should be developed as a matter of urgency.

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